Letters to the Editor

Please e-mail letters for publication to Dr Kamran Abbasi [kamran.abbasi@rsm.ac.uk]. Letters should be no longer than 300 words and preference will be given to letters responding to articles published in the *JRSM*. Our aim is to publish letters quickly. Not all correspondence will be acknowledged.

Count me in even if I am old!

Shah and McKenzie (*JRSM* 2007;**100**:352–3)[1] note that the 'Count Me In' census[2] does not present separate analyses for older patients. The census is a requirement of DRE, providing a one-day snapshot of mental health inpatients. It is not a research database, and has caveats.[2]

Shah and McKenzie raise an important issue. Admissions for dementia and depression in older black and minority ethnic (BME) patients can be explored readily and effectively through routinely available datasets such as Hospital Episode Statistics (HES), which provide a complete picture of inpatient activity and much supplementary information (e.g. on diagnosis). Ethnicity coding in HES 2005/06 was over 90% complete/valid for mental health specialty patients.

In response to the letter, we analysed admission rates for ages 65 and over from the 2006 census data, and also admissions in HES. Our findings are:

(1) In the 2006 census, age-standardized admission rates for minority ethnic groups at older ages (results available on request) show similar patterns to those reported for all ages. Results for a few minority groups failed to reach significance because of small numbers. Older BME patients in the census are too few in most ethnic groups to support analyses of subgroups within them (e.g. those detained).
(2) Compared with 10,334 inpatients aged 65 and over in the 2006 census, of whom 1098 were BME patients, there were about five times more admissions in HES (51,598 of whom 4850 were BME patients).

We support calls for better information on users of mental health services.[3] We've made recommendations for information developments[2] that, along with other information initiatives, we are pursuing with the relevant agencies, including the Department of Health. In the interim, researchers may want to draw on the possibilities offered by data sets such as HES, which are widely used for analysing access to and outcomes of inpatient care.[4,5]

Competing interests None declared.

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REFERENCES

1 Shah A, McKenzie K. Count me in even if I am old! *J R Soc Med* 2007; **100**:352–3
2 Healthcare Commission, Mental Health Act Commission and National Institute for Mental Health in England. *Count Me In: results of the 2006 national census of inpatients in mental health and learning disability services in England and Wales*. London: Healthcare Commission, 2007. Available at http://www.healthcarecommission.org.uk/_db/_documents/Count_ Me_In_2006.pdf
3 Aspinall PJ. Informing progress towards race equality in mental healthcare: is routine data collection adequate? *Adv Psych Treat* 2006;**12**: 141–51
4 Association of Public Health Observatories. *Ethnicity and health*. UK: AHPO, 2005. Available at http://www.lho.org.uk/Download/Public/9840/1/Ethnicity%20and%20Health%20web%20version.pdf
5 Bardsley M, Hamm C, Lowdell C, *et al*. *Developing Health Assessment for Black and Minority Ethnic Groups: Analysing Routine Health Information*. London: Health of Londoners Project and NHS Executive, 2000. Available at http://www.londonshealth.gov.uk/pdf/hiabme_s.pdf

The nose and sex: the nasogenital reflex revisited

Bhutta (*JRSM* 2007;**100**:268–274) reminds readers of the pre-eminent position of the nose in evolution and describes evidence linking olfaction and perhaps pheromones to human reproduction.[1] The significance of the nose, he notes, is under-appreciated in the medical literature. This was not always the case.

Over one hundred years ago, neurological reflexes emanating from the nose—termed the nasal reflex neurosis—were considered to be the cause of many symptoms, including symptoms related to the genitalia. In 1883 McKenzie, an otolaryngologist from Johns Hopkins Hospital, proposed a nasogenital reflex responsible for symptoms such as dysmenorrhea, pelvic pain, etc. and described improvements following nasal treatments.[2] In 1901 Fliess, an otolaryngologist and personal physician of Freud, described genital areas in the nose responsible for activating the proposed neurological pathways.[3,4]

The significance of a protuberant midline structure with paired erectile tissue was not lost on Freud, who collaborated with Fliess on such theories as inherent bisexuality. Freud's support of Fliess and his theories weakened after Fliess' negligent surgical care of Emma Eckstein and her later recanting of any relationship of nose bleeds to psychological stress.[5] Reports of the nasogenital relationship diminished in the early 20th century and espousal of the theory faded as medical knowledge advanced.

Recent quality-of-life research, however, documents the profound effect of chronic rhinosinusitis on general health

and the substantial improvements noted after nasal surgery.[6] Ironically, it would not be surprising if diminished libido and sexual performance were noted in chronic rhinosinusitis and improvement documented after nasal surgery—the nasogenital reflex redux.

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REFERENCES

1 Bhutta MF. Sex and the nose: human pheromonal responses. *J R Soc Med* 2007;**100**:268–74
2 Mackenzie J. Irritation of the sexual apparatus as an etiological factor in the production of nasal disease. *Am J Med Sci* 1884;**88**:360–5
3 Fleiss W. *Die Nasale Reflexneurose*. Wiesbaden, Germany: JF Bergman, 1893
4 Zucker A, Wiegand D. Freud, Fliess, and the nasogenital reflex: did a look into the nose let us see the mind? *Otolaryngol Head Neck Surg* 1988; **98**:319–22
5 Freud S. *The Complete Letters of Sigmund Freud to Wilhelm Fliess 1887-1904*. Mason JM (ed and trans) Cambridge, Mass: The Belknap Press of Harvard University Press, 1985
6 Bhattacharyya N. Clinical outcomes after revision endoscopic sinus surgery. *Arch Otolaryngol Head Neck Surg* 2004;**130**:975–8

Chronic diarrhoea

I read with interest the report by Gupta and colleagues (*JRSM* 2007;**100**:379) on their patient with chronic diarrhoea, a common clinical problem. They finally established that their patient had a rare disease, medullary thyroid carcinoma, and appropriate treatment was instituted. We are not told of the outcome, but hope that she did well.

Two lessons may be derived from this paper. First, after a battery of expensive laboratory investigations, together with sophisticated imaging and invasive endoscopies, it was subsequently found that there was a diffusely enlarged thyroid with enlarged lymph nodes. The important word here is 'subsequently' because an initial examination of the patient, using no more than eyes, ears and hands, should have revealed this elementary physical sign, thus saving a great deal of discomfort, time and money and determining an earlier treatment policy. The second lesson concerns the mention of 'mesenteric ischaemia' as a cause of chronic diarrhoea. 'Intestinal ischaemia' is a preferable term, as it is the intestine and not the mesentery that is ischaemic, but apart from that the statement is erroneous. There is not the slightest evidence that chronic ischaemia causes diarrhoea. The list of causes is lifted verbatim from an earlier review[2] but that paper in turn provides no support for the assertion. One wonders where it came from.

The principle is important. It is all too easy to compound mistakes by the uncritical acceptance of inherited wrong ideas.

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REFERENCES

1 Gupta S, Tibbs CJ, Farthing MJG, Pollok RCG. Chronic diarrhoea—all in the bowel? *J R Soc Med* 2007;**100**:379
2 Thomas PD, Forbes A, Green J, *et al*. Guidelines for the investigation of chronic diarrhoea, 2nd edition. *Gut* 2003;**52**(Suppl 5):v1–15

Chronic diarrhoea—author's response

I thank Mr Marston for his comments regarding our article (*JRSM* 2007;**100**: 379).[1] He raises two issues. Regarding the first, I agree that the patient may have been saved from all the invasive investigations if the thyromegaly and cervical lymph node enlargement had been identified earlier. I can only surmise that the clinical findings in the neck were not present or were subtle at the time of initial assessment. This case highlights the point that general physical examination of a patient provides vital clues to the diagnosis—a fact that is sometimes overlooked. It is our responsibility to emphasize the importance of this to the next generation of clinicians.

As for the second point, the causes of chronic diarrhoea were taken from a reputable peer-reviewed journal (*Gut*).[2] Ischaemia of the gut has been given different nomenclatures, including mesenteric ischaemia, gut ischaemia, bowel ischaemia and intestinal ischaemia. There is evidence that colonic ischaemia can present as chronic colitis, with endoscopy changes mimicking those seen in inflammatory bowel disease. In most cases, no cause is found and the episodes are considered to be due to localized non-occlusive ischaemia, perhaps due to small vessel disease.[3]

Mesenteric atherosclerosis can cause chronic mesenteric ischaemia (intestinal angina) where patients present with post-prandial abdominal pain, nausea, bloating and episodic diarrhoea. Malabsorption or constipation can occur. Objective evidence of ischaemia to small bowel causing these symptoms is difficult to obtain. However, focal segmental necrosis of the small bowel can cause symptoms indistinct from Crohn's disease.[3] There is a case report of small bowel ischaemic necrosis diagnosed by video capsule endoscopy.[4] This investigation and double balloon enteroscopy may shed more light on the pathophysiological changes that occur in the small bowel secondary to mesenteric ischaemia.

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REFERENCES

1 Gupta S, Tibbs CJ, Farthing MJG, Pollok RCG. Chronic diarrhoea—all in the bowel? *J R Soc Med* 2007;**100**:379
2 Thomas PD, Forbes A, Green J, *et al*. Guidelines for the investigation of chronic diarrhoea, 2nd edition. *Gut* 2003;**52**(Suppl 5):v1–15
3 Brandt JL, Boley LJ. Intestinal ischaemia. In: Feldman M, Friedman M, Sleisenger MH (eds). *Gastrointestinal and Liver Diseases: Pathophysiology, Diagnosis and Management*. 7th edition. Philadelphia: Saunders, 2002: Chapter 119
4 Lintsos C, Goulas S, Karagiannis S, *et al*. Diagnosis of small bowel ischaemic necrosis by capsule endoscopy. *Gastrointest Endosc* 2005;**62**: 439–40